STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	05/31/2011

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MILFORD CENTER	700 MARVEL ROAD MILFORD, DE 19963

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from May 23, 2011 through May 31, 2011. The deficiencies cited in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census for the first day of the survey was one hundred and twenty one (121). The stage two survey sample totaled thirty three (33).	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations made throughout the facility and interview, it was determined that the facility failed to prominently post and display survey results for residents, family, and visitors. Findings include: On 5/23/11 and 5/25/11, a tour of the facility's three units revealed a lack of signage indicating the location of the survey report. During an interview with E12 (Activity Director) on	F 167	New signage has been posted to notify residents, families and visitors of the Center survey results. New binders have been provided for the front lobby and resident lounge. The availability of the survey results will be an agenda item at the next resident council meeting. Random audits shall be completed over the next 90 days to assure the survey results are available for residents, families and visitors. This will be the responsibility of the Business Office Manager/designee and the Recreation Director/designee. The Business Office Manager and the Recreation Director shall report to the Administrator and QA Committee any issues of availability. The QA Committee shall assess and evaluate the information and provide recommendations as necessary to obtain and maintain compliance.	6-24-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Bruce Lewin | Administrator | 6-24-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 5/25/11 at 9:15 AM, E12 stated the survey report should be in the main lobby. E12 located the survey report mixed in amongst the magazines in the magazine rack in the main lobby. There was no signage in that area indicating availability of the survey report. The only signage found in the entire facility was a 5 x 7 frame in the foyer entrance of the facility. All other signage had been removed from the walls, during renovations, so that wall paper could be applied to the interior walls of the facility.	F 167		
F 241 SS=B	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure residents had a dignified dining experience. Findings include: 1. A lunch observation on 5/23/11 on the Homestead unit revealed staff filling disposable plastic cups with fluids. These cups were placed on the dining tables for the residents. The residents were eating lunch and drinking from the disposable plastic cups 2. A lunch observation on 5/26/11 on the Homestead unit revealed staff filling disposable plastic cups with fluids. These cups were placed on the dining tables for the residents. The	F 241	The use of disposable cups for resident meal service on the Homestead unit has been discontinued. Inservicing was completed on 6/24/11 for Dietary staff on the Homestead Dining Program including required equipment for service and dining. Random audits shall be completed over the next 90 days for proper delivery of necessary equipment to the Homestead Unit. This shall be the responsibility of the Food Service Director/designee. The Food Service Director shall report to the Administrator and the QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	6-24-11

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F 241	Continued From page 2 residents were eating lunch and drinking from the disposable plastic cups. An interview on 5/27/11 at 1:18 PM with E11(social worker), who was serving food on 5/26/11 revealed that the disposable cups were used because no other cups were sent up from the kitchen. She further revealed that disposable cups have been used on the Homestead unit for some time now. An interview on 5/31/11 with the food service director, E6 revealed that she had been on leave and was unaware that the Homestead unit was not receiving regular dining cups. This issue was corrected immediately.	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of other facility records, it was determined that the facility failed to maintain respiratory equipment in a sanitary manner for two of 33 sampled residents (R 19 and R 129). The findings include: 1. On 5/24/11 at 9:26 AM during a room observation, R 19's nebulizer mask was lying uncovered on top of the nebulizer machine. The tubing connected to the mask which had no date to indicate how long the mask had been in use or the last time it was changed.	F 253	Resident R129 is no longer in the Center. Resident R19 has had their respiratory equipment changed, labeled with a date and stored in a treatment bag when not in use to maintain sanitary condition. All other respiratory equipment is labeled, dated and stored properly. Inservicing for Nursing staff shall be completed on or before 7/1/11 regarding the use and maintenance of respiratory equipment including labeling and proper storage. Random audits shall be completed over the next 90 days for proper use, labeling and storage of respiratory equipment. This shall be the responsibility of the Asst Nursing Directors/designee. The Asst. Nursing Directors shall report to the Administrator and the QA Committee monthly any variances in the data collected. The QA Committee shall assess and	7-1-11

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F 253	Continued From page 3 Review of the facility's policy "11.9 Nasal Cannula", revised 4/1/07, documented that when a humidifier is used "label and date." The policy also documented that the nasal cannula should be labeled with date of initial set-up, to replace entire set-up every seven days and date and store in a treatment bag when not in use. 2a. On 5/23/11 at 3:00 PM during an observation of R 129's room the following unsanitary conditions were observed: oxygen nasal cannula tubing was lying on the seat cushion of the resident's recliner chair; an oxygen concentrator with a humidifier bottle half full had nasal cannula tubing wrapped around the flow meter and a portable oxygen cylinder attached to the resident's rolling walker had nasal cannula tubing wrapped around the top of the cylinder. On 5/24/11 at 11:15 AM R 129 was observed in bed asleep with the oxygen nasal cannula in place and flowing at five liters per minute. More nasal cannula tubing was observed on the cushion of the recliner chair and on the rolling walker. The resident's respiratory equipment (nasal cannula tubings and humidifier bottle) failed to be labeled with a date to indicate when the equipment was last changed. The respiratory equipment was also not stored in a manner to maintain sanitary conditions. 2b. On 5/27/11 at 1:30 PM during an observation of R 129's room with E16 (LPN) the following was revealed unlabeled and undated:nasal cannula tubing was wrapped around the tops of two oxygen cylinder tanks; the nasal cannula tubing on the resident was noted to have a date written in pink marker of "4/20" on the extension	F 253	evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	

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F 253	Continued From page 4 tubing connector junction. E16 stated that the tubing should be changed weekly and have a label or the date written. E16 was unable to verify when the other nasal cannula tubings had been changed and stated that all of the resident's tubing would be changed and labeled with a date. On 5/27/11 at 2:00 PM, the respiratory equipment findings pertaining to R 19 and R 129 were discussed with E 2 (DON) and E1 (Administrator). E 2 (DON) stated that when the respiratory equipment is not in use it should be stored in a plastic treatment bag. E 2 also confirmed that the equipment should be changed every seven days and labeled with a date at the time it is changed.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	Resident R111 has had care plan reviewed by the interdisciplinary team, revised to reflect accurate assessment and staging of the wound as well as current treatment interventions as noted on the Physician's Order Sheet. The wound is now closed. Resident R126 has had care plan reviewed by the interdisciplinary team and revised to reflect the declining status of the resident. In addition, the Homestead Program Director has implemented a log to track activity participation by those residents who are care planned for 1:1 and small group activities. Inservicing shall be completed on or before 7/1/11 for Facility staff on appropriate and timely revision of care plans quarterly as well as with any significant change in condition. Additionally Homestead staff have been educated regarding the tracking	7-1-11

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F 280	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure for two (R111 and R 126) out of 33 sampled residents their care plans had been revised when changes in care were implemented. Findings include: 1. Cross refer F314 example 1. Review of R111's February 2011 Physician's Order Sheet (POS) noted the following treatment orders: - Return to bed in afternoon - Apply Inzo (antifungal-designed to prevent moisture, urine and fecal matter from contacting skin) cream to buttocks and sacrum every shift and as needed - Anal area-cleanse with incontinence spray, apply Calmoseptine (protects and heals skin irritations) cream every shift and after every episode of incontinence The care plan for risk of skin breakdown implemented on 6/6/08 noted the following interventions: -assess skin condition with care daily and report abnormalities -weekly skin assessment by licensed nurse -provide peri care/incontinence care as needed -apply barrier cream with each cleansing -turn and/or reposition and check skin every two hours as needed Although the above care plan was implemented, the facility failed to revise the care plan to include	F 280	of activity participation for those care planned for 1:1 and small group activities. Random audits shall be completed over the next 90 days for appropriate and timely revisions of care plans on residents with a change in condition. This shall be the responsibility of the Nursing Director/designee and the Homestead Program Manager/designee. The Nursing Director and the Homestead Program Manager shall report to the Administrator and the QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	

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F 280	Continued From page 6 the treatment interventions as noted on the above February 2011 POS. In addition, review of R111's care plans revealed an actual skin breakdown related to incontinence, limited mobility: IAD (incontinence associated dermatitis) of the right buttock with most recent revision date of 5/25/11. However, record review lacked evidence of a care plan for the stage III pressure ulcer of the sacrum identified on 3/29/11. An interview with E2 (Director of Nursing) on 5/31/11 at 12:30 PM confirmed that the above care plan was not revised to reflect the new PU. 2. R 126 was admitted to the facility 6/7/08 with diagnosis which included Alzheimer ' s disease, Abnormal Posture and Symbolic Dysfunction. On 5/24/11 the resident was observed from 9:30-10:30 AM in the activity/dining area of the Homestead Unit. The resident was wheeled into a circle of residents who were participating in an activity of tossing a beach ball with E18 (Activity Aide/CNA). The resident ' s head was observed in a downward position with eyes closed, E18 made no attempt to engage the resident in the activity. On 5/25/11 at 2:30 PM, in the activity/dining area, the resident was observed sitting in a wheel chair, head down facing the left arm of the chair with eyes closed. E19 (CNA) attempted to involve the resident in the present activity (moving beaded objects on metal bars). The employee stated that the resident would not participate and had not	F 280		

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F 280	Continued From page 7 been participating in activities lately. On 5/25/11 during a review of the resident ' s care plan for at risk for limited meaningful engagement with E14, (LPN) revealed: the care plan was initiated on 6/24/08 with the last revision by computer intake of 3/29/11. The documented goal for the resident was " will increase social engagement as evidenced by participation in one to one visits, small groups and unstructured involvement (sic) with peers/family/friends/staff " ; the evaluation note documented that the resident continued to increase social engagement by participating in one to one visits, small groups and family visits and the resident loved to sing and talk about Philadelphia. Review of the resident ' s Progress Notes revealed an entry on 3/26/11 for a change in the medical and mental condition of the resident. The note documented that " resident leaning forward, head near her knees ...requiring extensive assist with ambulation ... " On 4/13/11 a Health Care Decision note documented that the changes noted by the physician and staff were discussed with the son, who in turn requested palliative care for his mother. On 5/25/11 at 2:20PM, E19 was asked for documentation regarding R 126 ' s activity participation over the last six months. E19 stated that the facility did not keep a record of the resident ' s activity participation. At 2:35PM, the resident ' s assessed activity goals and interventions were discussed with E14 (LPN) and E12(activity director). E12 stated that R 126 had a decline and no longer participated in activities.	F 280		

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F 280	Continued From page 8 The present care plan regarding activities failed to reflect the resident ' s changes and lack of participation.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that qualified persons provided the care in accordance with the written plan of care for one (R111) out of 33 sampled residents. When R111 acquired a new skin impairment on 2/28/11, the facility failed to accurately identify the type of wound. Findings include: Cross refer F314. R111 was originally admitted to the facility on 6/6/08 with diagnoses including hypertension, osteoporosis, hypothyroidism, psychosis, hyperlipidemia, Alzheimer's disease, and hypertension. On 2/28/11, a "Skin Integrity Report" was initiated which documented a new skin impairment of the right inner buttocks. Type of wound was noted as an incontinence associated dermatitis (IAD) with dimensions of 1 cm. (centimeter) length (L), by .5 cm. width (W), by less than .25 cm in depth (D). Subsequently, an order was obtained on 2/28/11	F 282	Resident R111 has had wound examined and reviewed by staff trained in wound staging and assessment. The wound is receiving appropriate treatment and the wound has continued to heal and has been noted as pink and closed as of 6/15/11. The record has been corrected to appropriately reflect the type and severity of the wound. In addition, wound rounds have been re-established to include Physician/Nurse Practitioner involvement in assessing wounds. Other residents with wounds have been accurately assessed and care plans include appropriate interventions. Inservicing for Nursing staff shall be completed on or before 7/1/11 on appropriate staging of wounds, the policies and procedures on skin integrity and notifying the wound nurse or a nurse manager immediately upon noting a skin impairment. The wound nurse or nurse manager will examine the wound within twenty four hours to assure proper assessment has occurred, appropriate treatment intervention is in place, and care plans reflect those treatment interventions as written on the Physician's Order Sheet. The current Wound nurse is scheduled for additional wound training on 6/27/11. Random audits shall be completed over the next 90 days on residents with wounds to ~~assure accurate assessment, appropriate~~	7-1-11

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F 282	Continued From page 9 to cleanse area with wound cleanser , apply hydrocolloid (are occlusive and adhesive wafer dressings which combine absorbent colloidal materials with adhesive elastomers to manage light to moderate amounts of wound exudate) every three days and as needed. Review of the "Wound Characteristic Guide" noted to review and document correlating characteristics with physician to obtain wound type diagnosis. In addition, definition for IAD included "diffused area of rash and/or excoriation due to incontinence." Although the characteristics of the wound on the 2/28/11 "Skin Integrity Report" as noted above were different from the above definition of an IAD, record review lacked evidence that the characteristics of the skin impairment were reviewed with the physician and a wound type diagnosis obtained. An interview with E2 (Director of Nursing/DON) on 5/31/11 at approximately 12:30 PM confirmed that there was a discrepancy between the description on the "Skin Integrity Report" and the description of the skin impairment on the "Wound Characteristics Guide." In addition, the characteristics of the skin impairment were not reviewed with the physician and the wound type diagnosis obtained. Subsequent wound assessments dated 3/11/11, 3/16/11, and 3/23/11 revealed relatively unchanged wound dimensions of 1 cm. L x .5 cm. W x (<) less than 0.1 cm. D. The following wound assessment completed by	F 282	treatment and accurate care planning. This shall be the responsibility of the Asst. Nursing Directors/designee. The Asst Nursing Directors shall report to the Administrator and QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	

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F 282	Continued From page 10 the facility's designated Wound Care Nurse (E10) dated 3/29/11 noted that this wound was assessed as a stage III pressure ulcer measuring 3 cm. L x 2.3 cm. W x < 0.2 cm. D with slough (dead tissue with colors ranging from yellow to brown). An interview with E3 (Associate Director of Nursing) on 5/31/11 at approximately 10:30 AM revealed that when R111's skin impairment was identified on 2/28/11, she was the facility's wound point of contact and that she should have accurately and thoroughly assessed the wound.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that the facility failed to accurately assess the risk of development of a pressure ulcer (PU), failed to accurately identify and assess a new PU, and failed to develop a care plan for one (R111) out of 33 sampled residents. The facility failed to reassess the intervention when R111 was assessed as "high risk" for the development of a PU on 1/27/11 utilizing the	F 314	Resident R111 has been re-assessed, has appropriate care plan interventions and an accurate, current Braden scale. The computer system that calculates Braden scale scores has been corrected. Other residents have accurate Braden scale on record and are being assessed to determine any changes in risk level. Inservicing shall be completed on or before 7/1/11 on the Skin Care delivery process, including identifying risk factors on the Braden scale, interventions for those risk factors, development and revision of care plans as risk factors for pressure ulcer development change. Additionally, instruction on appropriate departments to contact for assistance in preventing and healing pressure ulcers. Random audits shall be completed over the next 90 days to assure that Braden scales are being monitored, that residents with increasing risk are identified and care plans are developed and revised as appropriate.	7-1-11

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F 314	Continued From page 11 Braden Scale. In addition, the facility failed to ensure that the electronic medical records system which calculated the the total score on the Braden Scale and determined risk for developing a PU was accurate. Lastly, when R111 had a new skin impairment, it was inaccurately identified as a an incontinence associated dermatitis (IAD) and not a stage II PU of the sacrum. Findings include: R111 was originally admitted to the facility on 6/6/08 with diagnoses including hypertension, osteoporosis, hypothyroidism, psychosis, hyperlipidemia, Alzheimer's disease, and hypertension. Review of the most recent annual Minimum Data Set (MDS) assessment dated 1/31/11 revealed that the resident was severely impaired for daily decision making, required extensive assistance of two persons for bed mobility/transfer, and was incontinent. In addition, R111 did not have a PU, however, was at risk of developing a PU. Review of the facility's policy titled "Skin Integrity Care Delivery Process" indicated that all residents will be assessed for potential loss of skin integrity by using the Braden Scale for predicting PU on admission/re-admission, quarterly, and with any significant change in condition. Review of R111's Braden Scale noted that R111 was assessed as "mild risk" for the development of PU on 12/17/10. The subsequent Braden Scale dated 1/27/11 noted a change in R111's "Sensory Perception-ability to respond meaningfully to pressure-related discomfort" from	F 314	This shall be the responsibility of the Asst Nursing Directors/designee. The Asst Nursing Directors shall report to the Administrator and QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	

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F 314	Continued From page 12 "slightly limited" to "very limited", thus, assessing R111 as "high risk." R111's February 2011 Physician's Order Sheet noted the following treatment orders: - Return to bed in afternoon - Apply Inzo (antifungal-designed to prevent moisture, urine and fecal matter from contacting skin) cream to buttocks and sacrum every shift and as needed - Anal area-cleanse with incontinence spray, apply Calmoseptine (protects and heals skin irritations) cream every shift and after every episode of incontinence The care plan for risk of skin breakdown implemented on 6/6/08 noted the following interventions: -assess skin condition with care daily and report abnormalities -weekly skin assessment by license nurse -provide peri care/incontinence care as needed -apply barrier cream with each cleansing -turn and/or reposition and check skin every two hours as needed Record review lacked evidence of a reassessment of the above interventions after there was a change in R111's "Sensory Perception-ability to respond meaningfully to pressure-related discomfort" from "slightly limited" to "very limited." and was assessed as "high risk." An interview with E2 (Director of Nursing/DON) on 5/31/11 at approximately 12:30 PM revealed there was no system to review the outcome of the Braden Scale score, such as when R111's risk increased to "high risk." Thus, the above	F 314		

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interventions for the risk of skin breakdown were not reassessed when R111 was assessed at "high risk" on 1/27/11. On 6/3/11, the surveyor received information from the facility that the facility's electronic medical records system failed to take into account all the questions on the Braden Scale, thus, incorrectly assessed R111 as "high risk" and that the correct risk was "mild risk."

Although the R111 was assessed as a "high risk" for the development of PU, as indicated on the Braden Score completed on 1/27/11, the facility failed to reassess the interventions on the above care plan.

The care plan for actual skin breakdown related to incontinence, limited mobility: IAD right buttock with most recent revision date of 5/25/11 (during the survey) noted the following interventions:
-encourage resident to consume all fluids during meals
-monitor for verbal and nonverbal signs of pain
-pressure redistribution surface air mattress to bed
-pressure redistribution surface split cushion to chair
-provide wound treatment as ordered
-weekly wound assessment to include measurements and description of wound

On 2/28/11, a "Skin Integrity Report" was initiated which documented a new skin impairment of the right inner buttocks. Type of wound was noted as an IAD with dimensions of 1 cm. (centimeter) length (L), by .5 cm. width (W), by less than .25 cm. in depth (D). Subsequently, an order was obtained on 2/28/11 to cleanse area with wound

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cleanser , apply hydrocolloid (are occlusive and adhesive wafer dressings which combine absorbent colloidal materials with adhesive elastomers to manage light to moderate amounts of wound exudate) every three days and as needed.

Review of the Treatment Administration Record from 2/28/11 through 3/28/11 noted that the above treatment was completed as ordered to the right inner buttocks.

Review of the "Wound Characteristic Guide" noted "review and document correlating characteristics with physician to obtain wound type diagnosis. In addition, "definition for IAD included "diffused area of rash and/or excoriation due to incontinence."

Although the characteristics of the wound on the 2/28/11 "Skin Integrity Report" as noted above were different from the above definition of an IAD, record review lacked evidence that the characteristics of the skin impairment were reviewed with the physician and a wound type diagnosis obtained.

An interview with E2 (Director of Nursing/DON) on 5/31/11 at approximately 12:30 PM confirmed that there was a discrepancy between the description on the "Skin Integrity Report" and the description of the skin impairment on the "Wound Characteristics Guide."

Per the facility's above policy, when a skin integrity impairment is identified the following processes are to be initiated:
-report on the 24 hour summary report

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F 314	Continued From page 15 -complete a " Skin Integrity Report " -interdisciplinary care plan (ICP) to include approaches to stabilize or improve co-morbidities and interventions limiting the effects of risk factors associated with PU. -notify dietician for actual wounds -notify therapy department of actual wounds (e.g. pressure ulcer, venous ulcers, arterial ulcers, or diabetic ulcers which may respond to intervention) or -risk factors including impaired mobility, seating and positioning deficits, or swallowing deficits Record review lacked evidence that a ICP had taken place with notification of the dietician and therapy department. An interview with E2 (Director of Nursing/DON) on 5/31/11 at approximately 12:30 PM confirmed the same. Subsequent wound assessments dated 3/11/11, 3/16/11, and 3/23/11 revealed relatively unchanged wound dimensions of 1 cm. L x .5 cm. W x (<) less than 0.1 cm. D. The following wound assessment completed by the facility's designated Wound Care Nurse (E10) dated 3/29/11 noted that this wound was assessed as a stage III PU measuring 3 cm. L x 2.3 cm. W x < 0.2 cm. D with slough (dead tissue with colors ranging from yellow to brown). Nurse's Note (N.N.) dated 3/29/11 timed 1:49 PM by E10 documented "IAD on rt. (right) inner buttocks is now a stage III over the sacral bone-buttock measuring 3X2.3X<0.2. Area has some granulation with slough in the wound bed. Minimal serosanguineous drainage... Tx (treatment) changed from hydrocolloid to calcium	F 314		

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alginate extra. Also dietician consult to see about increasing protein for wound healing. Will start on Hi Cal per dietician."

An interview with E10 on 5/26/11 at approximately 3:20 PM revealed that the skin impairment worsened to a stage III PU when she observed the wound on 3/29/11 and was noted to have slough.

Review of the Nurse Practitioner's (E13) progress note dated 3/30/11 noted R111 developed an open ulcer over the inner buttock area on left.

Subsequently, on 3/29/11, the following orders were obtained as follows:
- discontinue hydrocolloid treatment to the wound and a new order to cleanse the area with wound cleaner, apply skin prep. to surrounding tissue, apply maxorb xtra alginate (calcium alginate-a wound dressing used to manage exudates in partial to full-thickness wounds, providing a moist environment for healing). Cover with border gauze daily and as needed.
- Hi Cal (nutritional supplement) 4 ounces by mouth twice a day for wound healing

A subsequent N.N. dated 4/6/11 and timed @ 12:43 PM by E9 noted healing stage III PU with dimensions of 1 cm L., 0.3 cm W., and <0.2 cm D with no slough. In addition, "...Air mattress is ordered for the bed and that resident on turning program." The following N.N. dated 4/7/11 timed 1:04 PM noted "...Air floatation mattress now in use."

On 6/7/11, the facility provided a report from E20 (Manager of Clinical Operations) dated 4/27/11

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F 314	Continued From page 17 which documented that E20 observed the wound and consulted E21 (Wound Care Consultant) and it was their assessment that the initial skin impairment on 2/28/11 was not an IAD based on the description but rather a stage II PU. In addition, the slough noted on the 3/29/11 assessment was likely exudate from the hydrocolloid dressing, thus, the stage was inaccurately staged as III.	F 314		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Residents R83 and R247 had an AIMS test completed. Resident R26 is receiving vital signs as ordered by the physician and documented in the record. Residents on antipsychotic medication have current AIMS tests completed. Residents vital signs are being completed and documented as ordered. Inservicing for Nursing staff shall be completed on or before 7/1/11 on the policy to complete AIMS tests and vital signs as well the recording requirements. Random audits shall be completed over the next 90 days for completion of AIMS tests and vital signs. This shall be the responsibility of the Asst Nursing Directors/designee. The Asst Nursing Directors shall report to the Administrator and QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7-1-11

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F 329	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R26, R83 and R247) out of 33 sampled residents, the facility failed to ensure medications were adequately monitored. Findings include: The facility's Pharmacy Services Policies and Procedures manual for the policy "3.9 Psychopharmacologic medication Use" stated, "3.1 Nursing staff complete the AIMS (Abnormal Involuntary Movement Scale) test on admission, re-admission, with change in status, every six months, and with a new medication/dosage order for patients on antipsychotic medications." 1. Review of R83's clinical record revealed the resident was receiving Risperdal (antipsychotic agent) since admission to the facility on 5/11/10. The clinical record lacked evidence of an AIMS (monitors for adverse side effects of the medication) having been completed at any time. During an interview with E10 (RN) and E14 (LPN) on 5/26/11, they confirmed that R83 had been receiving an antipsychotic medication since admission and that an AIMS had not been completed. 2. Review of R247's clinical record revealed the resident was receiving Risperidone (antipsychotic agent) since admission to the facility on 5/6/11. On 5/26/11 a second antipsychotic agent, Seroquel, was added to R247's medication regimen. The facility failed to complete an initial AIMS on admission and failed to complete one when Seroquel was added.	F 329		

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F 329	Continued From page 19 During an interview with E2 (Director of Nursing) on 5/31/11, E2 acknowledged the lack of AIMS monitoring for R247. 3. R 26 was admitted to the facility on 3/4/10 with diagnosis which included Hypertension, Congestive Heart Failure and Coronary Artery Disease. The resident's comprehensive care plan for cardiovascular symptoms included a nursing intervention to "Administer meds as ordered and assess for effectiveness and side effects and report abnormalities to physician." Review of the May 2011 Physician's Order Form (POF) revealed the following orders: Lisinopril 10 milligrams (mg) 1 tab everyday for hypertension (blood pressure medication), Plavix 75 mg 1 tab everyday and Coumadin daily for cardiac disease. There was also a 1/28/11 order for routine vital signs every week. Review of the resident's Medication Administration Records (MAR) from February-May 2011 revealed missing weekly vital signs (VS). The February , March and April MARs indicated that the 1/28/11 order for VS was to be done on the 7-3 shift. The February MAR revealed no documented VS for the first and third week of the month. The March MAR revealed no documented VS for the second and fifth week of the month. The April MAR revealed no VS for the first week of the month. The May MAR indicated that the 1/28/11 order was to be done on the 7 PM-7 AM shift. This MAR revealed no documented VS for the first and second week during the month of May.	F 329		

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F 329	Continued From page 20 On 5/26/11 during an interview and review of Point Click Care computer system with E5 Assistant Director of Nursing Unit (ADNU). It was revealed that there was no other documented evidence of VS for the month of May. The ADNU stated that the VS would either be located in the computer or on the MAR's and that there was no evidence to show that VS were done for the first two weeks of May. On 5/27/11 at 9:30 AM the missing VS from Feb-May 2011 were discussed with E2. Later during the same day E2 stated that the missing VS could not be located on other clinical records and that the resident's physician had been called and informed of the missing VS.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to distribute food under sanitary conditions. Findings include: 1. A lunch observation on 5/23/11 on the	F 371	Staff E11 is now using a hairnet while plating meals on the Homestead unit. Staff E17 is observing proper sanitation practice in the plating of meals in the main dining room. Inservicing shall be held on or before 7/1/11 for Homestead staff and Dietary staff regarding proper sanitation practices including the use of hairnets, gloves and handwashing. Random audits shall be completed over the next 90 days for proper sanitation protocols in the plating of meals on the Homestead unit and Main Dining Room. This shall be the responsibility of the Homestead Program Director/designee and the Food Service Director/designee. The Food Service Director and Homestead Program Director shall report to the Administrator and QA Committee monthly	7-1-11

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F 371	Continued From page 21 Homestead unit revealed that staff E11 (social worker) was observed plating residents' lunch meals from large serving containers without the use of a hair restraint. 2. A second lunch observation was conducted on 5/26/11. E11 was observed plating food on the Homestead unit without the use of a hair restraint. An interview with E11 on 5/27/11 confirmed she did not have her hair restrained on 5/23/11 and 5/26/11 while plating food for the residents' meals. 3. On 5/23/11 at 12:05 PM, in the main dining room, the following unsanitary conditions were observed: E17 (cook) was observed plating food for approximately 25 residents, E17 donned a pair of gloves without washing or sanitizing hands then proceeded to touch various unclean objects such as the handle of serving utensils, the doors entering the kitchen and the outside of a pitcher containing some beverage. Without changing gloves or sanitizing hands E17 reached into a plastic bag, removed a long sandwich roll, separated the roll by placing one gloved hand in the center, then put the chopped cheese steak meat into the roll with a spatula. This deficient practice was repeated for more than 10 residents during the dining observation.	F 371	any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 22 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the pharmacy failed to identify irregularities during the medication regimen review (MRR) for two (R83 and R247) out of 33 sampled residents. Findings include: 1. Review of the clinical record revealed that although MRRs were completed monthly from 5/2010 through 5/2011, the consultant pharmacist failed to identify and report the lack of AIMS monitoring while R83 was receiving Risperidone (antipsychotic agent). During an interview with E2 (Director of Nursing) on 5/31/11 at 10:50 AM, she acknowledged the lack of the AIMS monitoring for R83. 2. Review of the clinical record revealed that although an MRR was completed on 5/26/11, the consultant pharmacist failed to identify and report the lack of an initial AIMS for R247, who was receiving the antipsychotic agent, Risperidone. On 5/31/11 at 10:50 AM during an interview with E2, she acknowledged the findings.	F 428	AIMS tests have been completed on residents R83 and R247. Other residents on antipsychotic medication have current AIMS tests completed. Pharmacy provider and Consultant Pharmacist have been educated/instructed regarding the Center's policy regarding AIMS testing and the expectation that our MRR's include the review for the AIMS test. Random audits shall be completed over the next 90 days for the screening for AIMS tests on the MRR's for residents on antipsychotic medications. This shall be the responsibility of the Asst Nursing Directors/designee. The Asst Nursing Directors shall report to the Administrator and QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	6-24-11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 23 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	Medical Staff E15 is now following standard practices of infection control related to handwashing. Inservicing shall be completed on or before 7/1/11 on handwashing/glove use for Medical Staff. Random audits shall be completed over the next 90 days for compliance with standard practices of infection control and handwashing while providing patient care. This shall be the responsibility of the Nursing Director/designee. The Nursing Director shall report to the Administrator and the QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7-1-11

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 by: Based on observation and interview, it was determined that the facility failed to follow standard practices of infection control related to handwashing prior to providing wound care for one (R248) resident out of 33 sampled. On 5/26/11 at 2:10 PM an observation was made of R248 receiving wound care performed by E15 (physician) and E10 (wound care nurse). Prior to the onset of the wound care, E15 was seated at R248's bedside communicating with her using a white erase board. E15 then assisted R248 to a side lying position on her bed and lowered her slacks and brief and removed his stethoscope. E10 was observed washing her hands prior to donning gloves and assisting E15 with the wound care. E15 donned gloves and completed the wound care without washing his hands. After the wound care was completed, E15 did wash his hands. Findings were acknowledged by E2 during an interview on 5/31/11.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation in the kitchen and interview on 05/23/11 at 10:45 AM, it was determined that the facility failed to provide a safe	F 465	Additional mats were ordered and placed in the dish room to provide full coverage of the floor area. Random audits shall be completed over the next 90 days for proper use and placement of the floor mats. This will be the responsibility of the Food Service Director/designee. The Food Service Director shall report to the Administrator and the QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide	6-17-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	05/31/2011

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F 465	Continued From page 25 environment for staff in the dietary area. Findings include: 1. Two rubber floor mats were being used to provide cushioning for staff standing at the dish machine, and to prevent slipping and falling in the area. The floor around this machine gets wet when in use, making the tile floor slippery. The two mats in use covered only approximately one half of the wet floor surface leaving the remainder of the floor in that area as a slipping hazard. The surveyor found that area slippery and almost fell walking through this area. Two staff members were being utilized to operate the dish machine, but other staff could potentially walk through area. A follow-up interview with the Food Services Director, E6, indicated that more rubber mats would be placed on order so that the slippery floor surface could be covered.	F 465	recommendations as necessary to obtain and maintain compliance.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: May 31, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from May 23, 2011 through May 31, 2011. The deficiencies cited in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census for the first day of the survey was one hundred and twenty one (121). The stage two survey sample totaled thirty three (33).	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**	

Provider's Signature Bruce R Lewin Title Administrator Date 6-24-11

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report date completed 5/31/11, F167, F241, F253, F280, F282, F314, F329, F371, F428, F441, F465.	Cross refer to the CMS 2567-L survey report date completed 5/31/11, F167, F241, F253, F280, F282, F314, F329, F371, F428, F441, F465.